12. Tracking Claims

The provider is responsible for tracking claims sent to EDS. Tracking claims helps to assure that your claims are processed and paid in a timely manner. This section tells you how to track your claims.

12.1 How to Track Claims

Claims tracking involves three main activities:

- Keeping a copy of every claim. Note the date you sent each claim to EDS.

- Noting the date that each claim should appear on the Remittance and Status Report (also called the "Remittance Advice" or "RA").

- Reviewing each RA carefully to be sure it accurately reflects the information that was on your claim.

12.2 When Will You Receive an RA

The RA shows the disposition of claims processed during the current checkwrite cycle and claims that are still pending. You will receive an RA after each checkwrite date if you have claims being processed at the time of the checkwrite. The checkwrite schedule is included in the monthly Medicaid Bulletin sent by EDS to all Medicaid-enrolled providers. If you are enrolled to provide other services and you have more than one provider number, you will receive a separate RA for each provider number.

12.3 When Will a Claim Appear on the RA

A paper claim should appear in an RA as either paid, denied, returned, or in process within 30 days after being sent to EDS. An electronic claim submitted to EDS by 5:00 p.m. on the "electronic cut-off" date in the monthly Medicaid Bulletin should appear in the RA issued with the next checkwrite. See Section 13 for guidance on inquiring about claims that do not appear on the RA as expected.

12.4 What's on the RA

Every page of your RA is numbered. The following identifying information is at the top of each page:

- The facility's NAME, ADDRESS and PROVIDER NUMBER.

- The REPORT SEQ NUMBER - a sequential number assigned by EDS, beginning with your first RA for the calendar year. File your RAs in order using the REPORT SEQ NUMBER to be sure you receive them all.

- The DATE that the RA was produced. This is the same as the date on any accompanying check.

The RA begins with a cover page that shows the same identification information as above. Be alert to special information messages that may also appear on the cover page.

After the cover page, the RA will include one or more of the following sections that apply for the current checkwrite cycle. For example, if you do not have any adjusted claims for the checkwrite, that section will not be in your RA. The sections in an RA are:

- PAID CLAIMS

- ADJUSTED CLAIMS

- DENIED CLAIMS

- RETURNED CLAIMS

- CLAIMS IN PROCESS

- FINANCIAL ITEMS

- CLAIMS PAYMENT SUMMARY

12.5   Reviewing the Paid Claims Section

The PAID CLAIMS section shows all claims paid and partially paid since the previous checkwrite. If you had at least one part of a claim paid during the current checkwrite, the first section of your RA is PAID CLAIMS.

Claims are arranged alphabetically by the recipient's last name. Claims are broken down into the individual lines of information called "details." Details show the specific service and dates of service that were billed. The types of detail information that may appear for an adult care home provider's claims are:

- "229 Special Charges-Other" (Non-Emergency Medically Necessary Transportation);

- "W8251 Personal Care, Adult Care Home" (Basic ACH/PC for Licensed Beds 1-30);

- "W8251 Personal Care, Adult Care Home" (Therapeutic Leave for Licensed Beds 1-30);

- "W8258 Personal Care, Adult Care Home" (Basic ACH/PC for Licensed Beds 31 & above);

- "W8258 Personal Care, Adult Care Home" (Therapeutic Leave for Licensed Beds 31 & above);

- "W8256 ACH/PC Services, Eating" (Enhanced ACH/PC);

- "W8257 ACH/PC Services, Toileting" (Enhanced ACH/PC);

- "W8259 ACH/PC Services, Eating & Toileting" (Enhanced ACH/PC); and

- "W8255 ACH/PC Services, Ambulation/Locomotion" (Enhanced ACH/PC).

In the PAID CLAIMS section, you will find the following headings and information:

NAME AND RECIPIENT ID: The recipient's last name, first name, middle initial and Medicaid ID number.

CLAIM NUMBER: A 13 digit number assigned to each claim form by EDS. This is EDS' "internal control number" (ICN). Use this number when contacting EDS about a claim.

MED REC: The patient control number or medical record number listed in item 3 on the UB-92. If you did not enter a number, a "O" is printed.

ADMIT DATE: The admission date entered in item 17 on the UB-92.

The following information is shown for each detail line for a claim:

SERVICE DATES: The FROM DATE here is the first date of service that is being billed in the SERVICE DATE field in item 45 on the UB-92. If the information on the RA does not agree with your claim, send an adjustment to EDS.

DAYS OR UNITS: These are the total days or units from item 46 on the UB-92. If the information on the RA does not agree with your claim, send an adjustment to EDS.

PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION: The revenue or HCPCS code for the service and a brief description are listed. Note that the description is generated by the EDS system from the listed code - it is not printed as you entered it on the claim. If the revenue or HCPCS code on the RA does not agree with your claim, send an adjustment to EDS.

TOTAL BILLED: This should be the product of the number of service units billed (item 46) multiplied by the daily rate for the revenue and HCPCS codes billed. If the amount listed does not agree with your calculation, contact EDS' Provider Services.

NON ALLOWED: This is the difference between the TOTAL BILLED and the TOTAL ALLOWED. This will be "OO" on adult care homes' claims.

TOTAL ALLOWED: This is the total amount allowed for the detail line.

PAYABLE CUTBACK: The difference between what Medicaid allows and what Medicaid will pay for a particular charge based on the RCC or reimbursement amount. This will be "OO" on adult care homes' claims.

PAYABLE CHARGE: This is the amount Medicaid will allow before other deductions (patient liability and third party liability). For adult care homes' claims, this equals the TOTAL ALLOWED.

OTHER DEDUCTED CHARGES: These are deductions for items such as private insurance payments, other third party liability deductions, co-payments and patient liability. This will be "OO" on adult care homes' claims.

PAID AMOUNT: The amount payable to you for this claim (The PAYABLE CHARGE minus OTHER DEDUCTED CHARGES equals PAID AMOUNT).

EXPLANATION CODES: An Explanation of Benefit (EOB) code is entered in this column for each payment or partial payment. See the CLAIMS PAYMENT SUMMARY at the end of the RA for a list of all the codes appearing in this RA and an explanation of each code's meaning.

The following information is shown below all of the detail lines for each claim:

THLV DAYS USED: This is the total number of therapeutic leave (TL) days billed to Medicaid to date for the calendar year, if any enrolled adult care home or nursing facility has billed for TL for this resident.

DEDUCTIBLE: This is the amount of the Medicaid deductible, if the recipient has a deductible balance. It is usually "OO" for adult care homes' claims.

PAT LIAB, CO PAY, TPL: Patient liability, co-payments, and third party liability does not apply to adult care homes' claims. It is usually "OO" for adult care homes' claims.

At the end of the PAID CLAIMS section there is a summary of all paid claims, and the total amounts that were billed, allowed, and paid. There are also summary totals for each type of detail.

Review the PAID CLAIMS section to determine if all or part of a claim was paid, and if the information shown in the RA agrees with the information on the claim as submitted. If one detail in the claim was denied, determine the reason by reviewing the EOB. The claims processing system stops the review of a detail when it comes to a reason for denial. EDS reports this reason in the EOB, although there may be other errors in a detail. Before resubmitting a denied detail, double check all of the entries for the detail, not just the error or problem indicated by the EOB message.

12.6 Reviewing the Adjusted Claims Section

Review the ADJUSTED CLAIMS section to determine if adjustments were correctly processed.

If you had at least one adjustment processed since the last checkwrite, the next section of your RA is ADJUSTED CLAIMS. Much of the information is the same as for paid claims with "DEBIT TO" and "CREDIT TO" information added. See Section 13 for additional information on making adjustments.

DEBIT TO: These entries reflect "repayment adjustments" - situations in which you have been underpaid and are being paid additional money to rectify the underpayment. The number of the claim being adjusted follows DEBIT TO, the date the original claim was paid follows PAID, and the additional amount being paid is in the PAID AMOUNT column. Information on each detail line in the claim that is being adjusted is shown.

CREDIT TO: These entries reflect "recoupments" of funds that were paid incorrectly. The number of the claim being adjusted follows CREDIT TO, the date that the claim was paid follows PAID and the amount recouped is in the PAID AMOUNT column. Information on each detail in the claim that is being adjusted is shown.

12.7 Reviewing the Denied Claims Section

Review the DENIED CLAIMS section to determine which claims have been denied and the reason for denial. When reviewing this information, remember that the system stops the processing of a detail when it comes to a reason for denial. EDS reports this reason in the EOB, although there may be other errors in a detail. Before resubmitting a denied claim, check all of the entries, NOT just the error or problem indicated by the EOB.

If you had at least one claim with every detail on the claim denied, the next section of your RA will be DENIED CLAIMS. All of the information is the same as for paid claims; however, zeros are shown in all columns to the right of NON ALLOWED. The EOB code under EXPLANATION CODES shows the reason for the denial. An explanation of the code is in the CLAIMS PAYMENT SUMMARY at the end of the RA. Guidance for determining the cause for a denial is in Section 13.

12.8 Reviewing the Returned Claims Section

Review the RETURNED CLAIMS section to track returned claims.

If you had a least one claim during the checkwrite that cannot be processed as submitted, this will be your next section in the RA. Claims are returned with a letter of explanation from EDS. This section identifies a returned claim by listing the recipient's Medicaid ID number and name, the dates of service, the internal control number (ICN) assigned by EDS, the billed amount under NON ALLOWED, the patient account/medical record number beside MED REC and the EOB code indicating the reason for the return.

There is a summary at the end of the section showing the number and dollar amount of the rejected claims. These claims will not be processed unless you correct them and return them to EDS.

12.9   Reviewing the Claims in Process Section

This section lists the claims that have been received, but not yet completely processed. It appears in your RA only when there are pending claims.

Review the CLAIMS IN PROCESS section to account for any claims that have not been paid, denied or returned. DO NOT resubmit claims shown in this section.

NAME and RECIPIENT ID: The recipient's last name, first name, middle initial and Medicaid ID number.

SERVICE DATES: Following the recipient's name are the FROM and TO dates from the claim form.

CLAIM NUMBER: EDS' ICN control number for the claim.

TOTAL BILLED: The amount billed for the claim.

MED REC: The medical record or patient account number listed on the claim. If you did not enter a number, a "O" is printed.

EXPLANATION CODES: The EOB code that explains what is happening with the claim. An explanation of the code's meaning is in the CLAIMS PAYMENT SUMMARY section at the end of the RA.

12.10 Reviewing the Financial Items Section

Review this section to account for refunds and recoupments.

This section lists the payments refunded and amounts being recouped for individual claims. Any CREDIT TO entries in the ADJUSTED CLAIMS section that are being recouped appear again in this section. The section has the following headings to identify the claims involved and the financial details:

BENE ID: The recipient's Medicaid ID number.

BENE NAME: The recipient's last name and first initial.

FROM DOS: The FROM date of service on the involved claim.

TXN DATES: The date that the transaction was entered into the payment system.

CONTROL NUMBER: A 10 digit control number assigned by EDS for the transaction.

REFERENCE: Information that may help identify the transaction, such as a corresponding adjustment number.

ORIGINAL AMOUNT: The original amount of the transaction.

BEGINNING BALANCE: The amount remaining for the transaction prior to this RA. For example, if Medicaid initiated a recoupment for $1000.00 and $200.00 had already been recovered previously, the RA would show a BEGINNING BALANCE of $800.00 to be recouped.

APPLIED AMOUNT: The amount applied on this RA to the BEGINNING BALANCE in the RA.

NEW BALANCE: The amount left for the transaction after the checkwrite.

EXPLANATION CODES: The EOB code describing the transaction. An explanation for the code is in the CLAIMS PAYMENT SUMMARY at the end of the RA.

12.11   Reviewing the Claims Payment Summary

Compare the information in the CLAIMS PAYMENT SUMMARY with your records. Note that the information is also used for tax reporting purposes.

This section summarizes all payments and credits on the current RA as well as providing year-to-date figures.

The headings and information in this section include:

EFT NUMBER: If you are paid by electronic funds transfer, the EFT number is shown.

CLAIMS PAID: The number of claims paid.

CLAIMS AMOUNT: The total amount paid from the PAID CLAIMS section plus any amounts resulting from DEBIT TO adjustments in the ADJUSTED CLAIMS section.

WITHHELD AMOUNT: The total amount withheld from the RA due to CREDIT TO adjustments. This is obtained from each "Applied Amount" field in the Financial Items section.

NET PAY AMOUNT: The entry equals the CLAIMS AMOUNT minus the WITHHELD AMOUNT. In the CURRENT PROCESSED this is the amount of the check.

CREDIT AMOUNT: Amount refunded to Medicaid by your adult care home on this provider number.

NET 1099 AMOUNT: Your income for the provider number on this RA, as reported to the federal and state government for tax purposes. This is the NET PAY AMOUNT minus the CREDIT AMOUNT.

1099 INFORMATION (YEAR): This lists the current 1099 information for your home on the provider number for this RA. It includes your tax ID number (RECIPIENT IDENTIFYING NUMBER) and shows EDS as the payer.

Note: The last RA you receive each year serves as the annual 1099 form.

MESSAGE CODE SUMMARY: Each of the EOB codes used in the RA is explained.